

Authorization for Proxy Access to an Adult Patient's Portal

Patient's Information

Printed Full Name *(First, Middle Initial, Last)*

Date of Birth

MRN *(Internal use only)*

Printed Email Address *(Non-work email address recommended)*

Phone Number

I, the Patient listed above, acknowledge the following:

- Upon signing into the Patient Portal (the "Portal") for the first time, I will have read and acknowledged the *Olathe Health Patient Portal Information, Patient Portal Terms of Use, and Portal Privacy Policy.*
- I give permission to the Authorized Person/Proxy listed below, to be set up as a proxy to my Portal.
- I understand that I may revoke access for this Authorized Person/Proxy by contacting my provider's office or calling the helpline at (913) 355-4217 or emailing, PatientPortalQuestions@olathehealth.org
- I agree to waive and release Olathe Health (Olathe Medical Center, Miami County Medical Center, and Olathe Health Physicians) and all Olathe Health employees and staff, including the patient's physician(s), Olathe Health's affiliated entities, and Olathe Health and the affiliates' officers, directors, employees, agents, and successors, from any and all claims or causes of action that are in any way related to use of the Portal by me.

Signature of Patient

Date

Signature of DPOA / Personal Representative *(as applicable)*

Date

Authorized Person/Proxy's Information *(must be 18 years or older)*

Printed Full Name *(First, Middle Initial, Last)*

Date of Birth

Printed Email Address *(Non-work email address recommended)*

Relationship to Patient

I, the Authorized Person/Proxy listed above, acknowledge the following:

- Upon signing into the Portal for the first time, I will have read and acknowledged the *Olathe Health Patient Portal Information, Patient Portal Terms of Use, and Portal Privacy Policy.*
- I understand that my proxy access may be revoked at any time by the patient without prior notice to me.
- I agree to waive and release Olathe Health (Olathe Medical Center, Miami County Medical Center, and Olathe Health Physicians) and all Olathe Health employees and staff, including the patient's physician(s), Olathe Health's affiliated entities, and Olathe Health and the affiliates' officers, directors, employees, agents, and successors, from any and all claims or causes of action that are in any way related to use of the Portal by me.

Signature of Authorized Person/Proxy *(Preferred but not required)*

Date



**AUTHORIZATION OF PROXY
ACCESS TO AN ADULT
PATIENT'S PORTAL**

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PLACE
PATIENT LABEL
HERE